

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF  
MEDICAL CARE AND SERVICES PROVIDED

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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State/Territory: Maryland

CASE MANAGEMENT SERVICES  
HEALTHY START PROGRAM-HIGH RISK PREGNANT RECIPIENTS

- A. Target Group: A pregnant participant in the Healthy Start Program who is certified for and is receiving Medical Assistance benefits and who is identified as needing case management services due to psychosocial, health behavior, environmental, or physiological problems.
- B. Areas of State in Which Services Will Be Provided:
- X Entire State
- Only in the following geographic areas (authority of §1915(g)(1) of the Act is invoked to provide services less than statewide):
- C. Comparability of Services:
- Services are provided in accordance with §1902(a)(10)(E) of the Act.
- X Services are not comparable in amount, duration and scope. Authority of §1915(g)(1) of the Act is invoked to provide services without regard to the requirements of §1902(a)(10)(B).
- D. Definition of Services:
- (See Attachment)
- E. Qualifications of Providers:
- (See Attachment)
- F. The State assures that the provisions of case management services will not restrict an individual's free choice of providers in violation of §1902(a)(23) of the Act.

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1. Eligible recipients will have free choice of the providers of case management services.
  2. Eligible recipients will have free choice of the providers of other medical care under the plan.
- G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
- H. Reimbursement Methodology:

See Attachment 4.19 A&B, Page 36-37

**D. Definition of Services.**

1. **Healthy Start Program** means a program designed to identify and address medical, nutritional, and psychosocial predictors of poor birth outcomes and poor child health by providing enhanced prenatal and postpartum services to pregnant and postpartum female recipients and enhanced follow-up services to identify high-risk infant and child recipients.
2. **Case Management Home-Visiting Services** means home-based, case management services which will assist pregnant participants in gaining access to needed financial, medical, social, housing, educational, mental health, counseling, and supportive services.
3. These services are targeted to specific high-risk groups identified through the Healthy Start risk assessment tools. They are provided to pregnant participants with psychosocial, health behavior, environmental, or physiological problems and who are identified as needing case management services through the Healthy Start Enriched Home-Visiting Services, using the Maternity Home-Visiting Summary Form, Instructions, and Assessment Guidelines.
4. **Enriched Home-Visiting Services** means home-based assessment, planning, implementation, and evaluation of family-focused, comprehensive services as they relate to a pregnant or postpartum participant's health. These services are delivered by registered nurses.
5. A unit of Case Management Home-Visiting Services is defined as one home visit by a Case Management Home-Visiting Services Coordinator. These services shall include the following:
  - a. A face-to-face evaluation of a participant to determine the present condition, living environment, background, and needs. This may not include laboratory tests or a hands-on medical or psychological examination.
  - b. Development of a home-visiting plan (if not already developed through an Enriched Home-Visiting Service) and its implementation, with the participation and approval of the participant or legally authorized representative or representatives. The participant is free to reject any or all parts of the plan and may request other services. The Case Management Home-Visiting Services Coordinator may not enforce a plan of care or restrict the participant only to those recommended services.

- c. Referral to providers selected by the participant from among those qualified and available.
  - d. Assisting the participant in gaining access to the needed and desired services, and arranging for and linking the participant with those services.
  - e. Coordination of providers to whom the participant is referred, including managing and resolving conflicts between providers or between providers and the participant.
  - f. Providing the participant with counseling concerning use of community resources and regarding health, social, educational, financial, housing, and other needs.
  - g. Advising the participant on accessing government entitlement programs.
  - h. Coordinating with the participant's family members for implementation of the care plan, including counseling and training of family members as appropriate.
6. Case Management Home-Visiting Services may not be:
- a. Provided as an integral and inseparable part of another covered Program service;
  - b. Provided as an administrative function necessary for the proper and efficient operation of the State's Medical Assistance plan;
  - c. Rendered in connection with the implementation of services under Sections 1915(b), (c), or (g) of the Social Security Act; or
  - d. Part of institutional discharge planning.

**E. Qualifications of Providers.**

- 1. General requirements for participation in the Medical Assistance Program are that providers shall:
  - a. Meet the following licensure requirements, and verify the licenses and credentials of all professionals employed by the provider:
    - 1) Registered nurses providing Case Management Home-Visiting Services for the Healthy Start Program shall be licensed in the jurisdiction in which services are provided.

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- 2) Social workers providing Case Management Home-Visiting Services for the Healthy Start Program shall be licensed in the jurisdiction in which services are provided, and
  - 3) Licensed practical nurses providing Case Management Home-Visiting Services for the Healthy Start Program shall be licensed in the jurisdiction in which services are provided;
- b. Apply for participation in the Maryland Medical Assistance Program using an application form designated by the Department of Health and Mental Hygiene;
  - c. Be approved for participation by the Maryland Department of Health and Mental Hygiene;
  - d. Have a provider agreement with the Department of Health and Mental Hygiene in effect;
  - e. Be identified as a Maryland Medical Assistance Program provider by issuance of an individual provider number;
  - f. Verify the eligibility of recipients;
  - g. Accept payment by the Medical Assistance Program as payment in full for services rendered and make no additional charge to any person for the covered services specified in Section D. "Definition of Services" above;
  - h. Provide services without discrimination on the basis of race, color, sex, national origin, marital status, physical or mental handicap;
  - i. Maintain adequate records concerning service provision for a minimum of 5 years and make them available, upon request, to the Maryland Department of Health and Mental Hygiene or its designee;
  - j. Not knowingly employ or contract with any person, partnership, or corporation which has been disqualified from the Maryland Medical Assistance Program to provide or supply service to Medical Assistance recipients, unless prior written approval has been received from the Department of Health and Mental Hygiene;
  - k. Agree that claims rejected for payment due to late billing may not be billed to the participant;
  - l. Not place a restriction on the recipient's right to choose the provider;

- m. Agree that if the Medical Assistance Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or has not been preauthorized, the provider may not seek payment for that service from the participant; and
  - n. Be selected by the participant from among qualified providers.
2. Specific requirements for participation in the provision of Case Management Home-Visiting Services are that providers shall:
- a. Be a Home-Visiting Services provider employing appropriately qualified registered nurses who have demonstrable experience in serving high-risk and low-income maternal, infant, and child populations;
  - b. Provide directly or subcontract for the provision of three or more Specialty Services;
  - c. Receive funding through, or be a subcontractor of an agency which receives funding through, the Maternal and Child Health Services Block Grant;
  - d. Demonstrate expertise in serving high risk and low-income maternal, infant, and child populations, including pregnant adolescents;
  - e. Contact the participant within 10 working days of the receipt of the referral, unless client-related extenuating circumstances are documented;
  - f. Have formal policies and procedures which specifically address the provision of Home-Visiting services to maternal, infant, and child populations;
  - g. Make reports available to the Program of Home-Visiting services provided to participants;
  - h. Be knowledgeable of the eligibility requirements and application procedures of the applicable federal, State, and local government assistance programs;
  - i. Maintain a current listing of medical, social, housing assistance, mental health, financial assistance, education and training, counseling, and other support services available to low income pregnant women and children;

- j. Strictly safeguard the confidentiality of the participant's record so as not to endanger the participant's employment, family relationships, and status in the community;
  - k. Agree to on-site visits by Department staff to monitor adherence to the covered services for Enriched Home-Visiting Services and Case Management Home-Visiting Services; and
  - l. Have an agreement with the Department for provision of Enriched Home-Visiting Services and Case Management Home-Visiting Services under the Healthy Start Program.
3. A Case Management Home-Visiting Services Coordinator is an individual, employed by the Home-Visiting Services Provider, who is one of the following:
- a. A registered nurse;
  - b. A licensed social worker;
  - c. A licensed practical nurse; or
  - d. An individual with a bachelor's degree from an accredited college or university, who works under the direct supervision of a registered nurse or licensed social worker, and who has at least two years of experience rendering clinical casework.

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